

HB

288

<TARGET><BILL>HB 288</BILL><SUBJECT>HB
288</SUBJECT><COMM>HHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE

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REPRESENTATIVE WES KELLER DISTRICT 14

HOUSE BILL 288 SPONSOR STATEMENT

"An Act prohibiting denial or withholding of medical assistance eligibility or coverage for a prisoner."

House Bill 288 addresses a situation within the Department of Health and Social Services that affects the Department of Corrections. Many Alaskans receive medical care through the Medicaid system. It is a program, partially funded by the federal government designed to assist less fortunate people with their health needs.

The intent of HB 288 is to identify why an individual who is incarcerated in a state correctional facility may no longer use Medicaid for health needs. Based on 7 AAC 100.068 inmates are allowed to maintain Medicaid eligibility so they may return to the system after serving their sentence, but it denies the use of Medicaid while in custody. This regulation references several sections of AS 47.05 that does not seem to address the issue either way. As it is the state pays the full amount of an inmate healthcare while in custody.

House Bill 288 will serve to clarify legislative intent after hearing from the department. It will require a billing process to Medicaid to cover a portion of the cost for care of these eligible inmates. While there will more than likely be some costs associated with management of the program, the increased federal receipts should more than off-set any fiscal impact.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version HB288
 Fiscal Note Number _____
 () Publish Date _____

Identifier (file name) HB288-DHSS-HCMS-2-17-12 Dept. Affected Health and Social Services
 Title Med. Assistance Eligibility: Prisoners Appropriation Medicaid Services
 Allocation Health Care Medicaid Services
 Sponsor Representative Keller
 Requester House HSS Committee OMB Component Number 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
			FY14	FY15	FY16	FY17	FY18
OPERATING EXPENDITURES	FY13	FY13	FY14	FY15	FY16	FY17	FY18
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**	**	**	**	**	**	**

FUND SOURCE		(Thousands of Dollars)					
1002	Federal Receipts						
1003	GF Match						
1004	GF						
1005	GF/Prgm (DGF)						
1037	GF/MH (UGF)						
1178	temp code (UGF)						
TOTAL		**	**	**	**	**	**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated **SUPPLEMENTAL (FY12) operating costs** _____ (separate supplemental appropriation required,
 (discuss reasons and fund source(s) in analysis section)

Estimated **CAPITAL (FY13) costs** _____ (separate capital appropriation required)
 (discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

This is the initial version of the fiscal note for this bill.

Prepared by Kimberli Poppe-Smart, Deputy Commissioner
 Division Health Care Services
 Approved by Nancy Rolfzen, Assistant Commissioner
DHSS Finance & Management Services

Phone 907-269-7827
 Date/Time 2/17/12 4:00 PM
 Date 2/17/2012

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. HB288

Analysis

This proposed legislation amends AS 47.07.020 by adding subsection (o) To the extent consistent with federal law, a person's eligibility or coverage for medical assistance under this chapter may not be denied or withheld on the basis of the person's confinement to, or release on furlough from, a correctional facility if the person is in the custody of the state. In this subsection, "correctional facility" has the meaning given in AS 33.30.901.

Under federal Medicaid rules, prisoners can only be eligible for Medicaid during the period of time that they are receiving inpatient services in medical facilities outside of the correctional facility. Prisoners must still meet Medicaid eligibility criteria. For the population of prisoners age 21 and older, the current Medicaid eligibility requirements include that the prisoner be aged 65 or older, blind, disabled, or pregnant. The potential number of eligible prisoners would increase in January of 2014 if the Medicaid expansion under the Affordable Care Act is implemented.

Actual data for reduced costs associated with Department of Corrections medical-fees-for-service and the related increase to Medicaid expenditures cannot be determined at this time because DOC does not track data on offenders using Medicaid eligibility criteria. These numbers will be further refined through the eligibility process identifying offenders who qualify under the eligibility criteria. However, Department of Corrections expenditures would be 100 percent state funds and Medicaid expenditures would be a mix of state and federal funds (currently 50% federal). The cost of inpatient hospitalization is substantial, over \$11,000 per Medicaid recipient using that service in FY2011. Although costs for prisoners might be somewhat different than the general Medicaid population, replacing half of the state funds with federal funds could provide significant savings to the State.

In addition to Medicaid expenditures for services, there would also be an administrative cost associated with providing eligibility to and processing claims for prisoners while they were inpatients. But without a better idea of the numbers of prisoners impacted, it is not possible to determine the level of administrative effort required by the Divisions of Public Assistance and Health Care Services. For example, while placing small numbers of prisoners on Medicaid and tracking their expenditures while inpatients could be handled manually, if a large number of prisoners needed to be covered, the Department would need to make modifications to its eligibility and claims payment systems in order to track these expenditures. The cost of making a modification to the Medicaid Management Information System to permit minimal tracking would be between \$50,000 to \$75,000, of which 75% would be federal funds.

FISCAL NOTE

STATE OF ALASKA cost # codes
 2012 LEGISLATIVE SESSION

Bill Version HB288
 Fiscal Note Number _____
 Publish Date _____

Identifier (file name) HB288-DOC-OC-02-20-12 Dept. Affected DOC
 Title "An Act prohibiting denial or withholding medical assistance eligibility or coverage for a prisoner" Appropriation Admin & Support
 Allocation Commissioner's Office
 Sponsor Representative Keller
 Requester Health and Social Services Committee OMB Component Number 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
			FY14	FY15	FY16	FY17	FY18
OPERATING EXPENDITURES	FY13	FY13	FY14	FY15	FY16	FY17	FY18
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**	**	**	**	**	**	**

FUND SOURCE		(Thousands of Dollars)					
1002	Federal Receipts						
1003	GF Match						
1004	GF						
1005	GF/Prgm (DGF)						
1037	GF/MH (UGF)						
1178	temp code (UGF)						
TOTAL		**	**	**	**	**	**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 (separate supplemental appropriation required;
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 (separate capital appropriation required)
 (discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

This is the original version of the bill.

Prepared by Leslie Houston, Director
 Department of Corrections - Administrative Services
 Approved by Joseph D. Schmidt, Commissioner
 Department of Corrections

Phone 907-465-3339
 Date/Time 02/20/2012 10:30AM
 Date 2/29/2012

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. HB288

Analysis

This proposed legislation amends AS 47.07.020 by adding subsection (o) to the extent consistent with federal law, a person's eligibility or coverage for medical assistance under this chapter may not be denied or withheld on the basis of the person's confinement to, or release on furlough from, a correctional facility if the person is in the custody of the state. In this subsection, "correctional facility" has the meaning given in AS 33.30.901.

Under federal Medicaid rules, prisoners can only be eligible for Medicaid while during a period of time that they are receiving inpatient services in medical facilities outside of the correctional facility. Offenders must meet Medicaid eligibility criteria. The categories of Medicaid eligible inmates primarily cover: inmates 65 years and older, blind, disabled, or pregnant.

Actual data for reduced costs associated with medical-fees-for-service cannot be determined because the Department of Corrections (DOC) does not track data on offenders using Medicaid eligibility criteria. These numbers will be further refined through the eligibility process identifying offenders who meet the Medicaid eligibility criteria.

7 AAC 100.068. Living in a public institution

(a) Except as provided in (b) and (c) of this section, an individual residing in a public institution, regardless of whether placement was voluntary or involuntary, is not eligible for Medicaid under any category while residing in the public institution, unless the individual is

(1) living in a public institution solely to receive educational or vocational training; or

(2) placed in a public institution on a short-term emergency basis pending placement in a living arrangement appropriate to the individual's needs.

(b) An individual who is a Medicaid recipient at the time that individual enters a penal institution and who continues to meet all other applicable Medicaid eligibility requirements, may retain eligibility but may not receive Medicaid-covered services while an inmate.

(c) Notwithstanding (a) of this section, if a substance abuse treatment facility or a correctional halfway house is on contract with the state to provide treatment or monitoring, an individual residing in that facility may receive Medicaid services if otherwise eligible for Medicaid under this chapter.

(d) In this section,

(1) "inmate" means an individual who is living in a penal institution or public institution that is not a medical or educational institution; "inmate" includes an individual who

(A) is on temporary furlough; or

(B) has temporarily left the penal or public institution facility for treatment in an acute care medical facility;

(C) repealed 1/1/2011;

(2) "penal institution" means a correctional or holding facility for individuals who are held as ► inmates◄;

(3) "public institution" means an institution, including a penal institution, that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control; "public institution" does not include a medical institution.

History: Eff. 7/20/2007, Register 183; am 1/1/2011, Register 196

Authority: AS 47.05.010

AS 47.07.020

AS 47.07.040

2012 Legislature - Operating Budget Allocation Summary - Governor Structure

**Numbers and Language
Fund Groups: General Funds**

Agency: Department of Corrections

Allocation	[1] 11Actual	[2] 12 CC	[3] 12 Auth	[4] 12MgtPIn	[5] Adj Base	[6] Gov	[6] - [1] 11Actual to Gov	[6] - [4] 12MgtPIn to Gov	[6] - [5] Adj Base to Gov
Population Management (continued)									
Electronic Monitoring	2,227.7	2,696.5	2,697.1	3,052.1	3,087.5	3,396.6	1,168.9 52.5 %	344.5 11.3 %	309.1 10.0 %
Community Jails	6,411.8	7,603.4	7,603.4	7,603.4	7,603.4	7,603.4	1,191.6 18.6 %	0.0	0.0
Community Residential Centers	21,032.9	21,906.8	21,906.8	21,906.8	21,906.8	22,759.5	1,726.6 8.2 %	852.7 3.9 %	852.7 3.9 %
Parole Board	825.9	824.5	824.8	824.8	838.4	838.4	12.5 1.5 %	13.6 1.6 %	0.0
Appropriation Total	194,862.1	208,416.3	209,673.8	209,673.8	209,655.6	240,723.5	45,861.4 23.5 %	31,049.7 14.8 %	31,067.9 14.8 %
Inmate Health Care									
Behavioral Health Care	6,274.1	6,756.9	6,759.8	6,759.8	6,889.2	7,279.1	1,005.0 16.0 %	519.3 7.7 %	389.9 5.7 %
Physical Health Care	31,965.4	32,346.3	32,352.3	32,352.3	32,690.6	32,690.6	725.2 2.3 %	338.3 1.0 %	0.0
Appropriation Total	38,239.5	39,103.2	39,112.1	39,112.1	39,579.8	39,969.7	1,730.2 4.5 %	857.6 2.2 %	389.9 1.0 %
Offender Habilitation									
Education Programs	427.2	504.8	504.9	504.9	510.4	510.4	83.2 19.5 %	5.5 1.1 %	0.0
Vocational Education Programs	142.9	150.0	150.0	150.0	150.0	306.0	163.1 114.1 %	156.0 104.0 %	156.0 104.0 %
Domestic Violence Program	173.2	175.0	175.0	175.0	175.0	175.0	1.8 1.0 %	0.0	0.0
Substance Abuse Treatment	2,324.1	2,456.6	2,456.7	2,456.7	2,462.5	2,462.5	138.4 6.0 %	5.8 0.2 %	0.0
Sex Offender Management	2,158.9	2,767.1	2,767.4	2,767.4	2,796.2	3,146.2	987.3 45.7 %	378.8 13.7 %	350.0 12.5 %
Appropriation Total	5,226.3	6,053.5	6,054.0	6,054.0	6,094.1	6,600.1	1,373.8 26.3 %	546.1 9.0 %	506.0 8.3 %
24 Hr Institutional Utilities									
24 Hr Institutional Utilities	7,644.3	7,724.2	8,444.2	8,444.2	7,724.2	7,724.2	79.9 1.0 %	-720.0 -8.5 %	0.0
Appropriation Total	7,644.3	7,724.2	8,444.2	8,444.2	7,724.2	7,724.2	79.9 1.0 %	-720.0 -8.5 %	0.0
Agency Total	252,315.7	268,186.7	270,176.9	270,176.9	270,164.4	302,328.2	50,012.5 19.8 %	32,151.3 11.9 %	32,163.8 11.9 %
Funding Summary									
Unrestricted General (UGF)	236,071.6	245,920.4	247,910.6	247,910.6	247,888.5	280,743.2	44,671.6 18.9 %	32,832.6 13.2 %	32,854.7 13.3 %
Designated General (DGF)	16,244.1	22,266.3	22,266.3	22,266.3	22,275.9	21,585.0	5,340.9 32.9 %	-681.3 -3.1 %	-690.9 -3.1 %



LEGISLATIVE RESEARCH SERVICES

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Memorandum

TO: Representative Wes Keller
FROM: Chuck Burnham, Legislative Analyst
DATE: February 20, 2012
RE: Medical Costs and Medicaid Eligibility for Alaska Inmates
LRS Report 12.181

You asked us to estimate the cost to the state of providing healthcare for Alaska inmates. You also wanted to know how much could be saved if inmates who qualified for Medicaid at the time of incarceration were permitted to continue receiving benefits under that program.

In his fiscal year (FY) 2013 operating budget, Governor Parnell has requested \$34.66 million to fund the healthcare costs of inmates.¹ This marks an increase of roughly 9.1 percent over the FY 2012 budget request, which likely reflects growth in both the cost of healthcare and the prisoner population.²

We contacted the Alaska Department of Corrections (DOC) for assistance in determining what proportion of inmates was eligible for Medicaid at the time of their incarceration.³ According to Administrative Services Division Director April Wilkerson, the DOC does not collect such information on a consistent basis.⁴ We were unable to locate a source for either the extent of Medicaid eligibility among Alaska prisoners or data on average income levels for prisoners, from which we may have been able to extrapolate a reliable estimate of eligibility rates.

In the absence of solid data, we can only speculate on the number of Medicaid eligible prisoners using information on program participation rates for the Alaska population overall. According to the Kaiser Family Foundation, in 2010 approximately 17 percent of Alaskans qualified for Medicaid.⁵ Although we find it likely that qualification rates among inmates would be higher than that of the population at large, we can nonetheless use the 17 percent figure as the minimum portion of incarcerated individuals that were eligible for Medicaid benefits at the time they were jailed. By applying that proportion to the total inmate healthcare costs, we can speculate that roughly \$6 million of the FY2013 budget request is for prisoners who would otherwise be likely to qualify for Medicaid.⁶ Under current Federal Medical Assistance Percentages (FMAP), which establish Medicaid reimbursements to states, Alaska receives 50 percent of eligible costs from federal coffers.⁷ Therefore, assuming our speculations are reasonably accurate, the total savings that would accrue were inmates eligible for Medicaid in 2013 is roughly \$3 million.

Clearly, our estimate above is highly speculative in not only the proportion of eligible inmates, but also in assuming that those prisoners' health costs are, on average, equivalent to those of other inmates. Nonetheless, we find it likely that this method

¹ The overall cost is comprised of \$1,964,500 for behavioral healthcare and \$32,690,600 for physical healthcare. The operating budget is being considered as HB 284.

² Current inmate population figures are not yet available; however, between January 2008 and December 2010, the average monthly number of Alaska prisoners increased approximately 7.3 percent, from 5,344 to 5,743, including nearly one thousand housed in correctional facilities out-of-state. We are aware of nothing suggesting that the upward trend will be reversed in the current year. More information on prisoner numbers and demographics is available from the Alaska Department of Corrections at <http://www.correct.state.ak.us/corrections/admin/docs/profile2010.pdf>.

³ That prisoners can receive Medicaid benefits under certain circumstances if otherwise eligible is a result of a rule promulgated in 1997 by the U.S. Department of Health and Social Services; however, few states have taken advantage of this rule and, like Alaska, keep inmates ineligible under state law.

⁴ Occasionally, healthcare providers discuss with inmates what benefits they have or will be eligible for upon release; however, this sort of anecdotal information is insufficient for purposes of extrapolating overall Medicaid eligibility. Ms. Wilkerson can be reached at 907-465-3460.

⁵ <http://www.statehealthfacts.org/profileglance.jsp?rgn=3&rgn=1>.

⁶ As you know, 7 AAC 100.068 makes individuals residing in public institutions ineligible for Medicaid.

⁷ Current FMAP rates are available online at <http://aspe.hhs.gov/health/fmap.htm>.

can be used to generate a plausible range of potential savings incurred should Medicaid be opened to prisoners through this simple formula:

$$\text{Percentage of eligible inmates} \times \text{total inmate healthcare costs} \times \text{FMAP}$$

Or, in our calculation:

$$0.17 \times \$34.66 \text{ million} \times 0.50$$

Using this formula, one can produce estimates based on a range of eligibility levels. For instance, if we assume that one-third of prisoners were Medicaid eligible at the time of their respective incarcerations, the calculation would be as follows:

$$0.33 \times \$34.66 \text{ million} \times 0.50 = \$5.72 \text{ million}$$

Although we hesitate to put too fine a point on this speculation, if we assume eligibility rates among inmates ranges from that of the general population—17 percent—to a rate more than twice that level, say 40 percent, the range of savings available from opening Medicaid benefits to Alaska inmates is roughly \$3 million to \$7 million for FY2013. It is important to note, however, that this discussion may well be largely moot beginning in 2014.

Inmate Healthcare under the Affordable Care Act

Assuming that the federal Department of Health and Social Services does not alter its interpretation of the Patient Protection and Affordable Care Act (P.L. 111-148), Section 2001(a)(3) of the law will extend Medicaid to all Americans under age 65 with income below 133 percent of the federal poverty limit. That section further provides that states will be reimbursed for “newly eligible individuals” for 100 percent of eligible costs in the first three years, 2014-2016, after which reimbursement will slowly decrease to 90 percent for 2020 and subsequent years. Should this section be enacted as written, it appears that the inmate healthcare budget in Alaska and other states could be reduced dramatically.⁸

We hope this is helpful. If you have questions or need additional information, please let us know.

⁸ Full text of the federal Act is available at <http://housedocs.house.gov/energycommerce/ppacacon.pdf>. A helpful article on the coverage of inmates under the Act was recently published in *Governing* magazine online (<http://www.governing.com/blogs/politics/Medicaid-Expansion-Covering-Nearly-All-State-Prisoners.html>.)



STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

DEPARTMENT OF CORRECTION
INMATE MEDICAID ELIGIBILITY

AUGUST 2010

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

SUMMARY

PURPOSE

This audit report evaluates whether the Department of Correction (Department) could reduce inmate health care costs by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services and makes recommendations so Department management can take appropriate corrective action.

RESULTS

The Department could save about \$11.5 million a year by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services. Because the federal government reimburses the State approximately \$.65 for every \$1.00 spent on Medicaid, billing Medicaid for eligible inmate health care would reduce the Department's costs by transferring those costs to the federal government. The Department would also realize reduced costs because hospital and medical services for eligible inmates would be paid at Medicaid rates that are lower than the rates currently paid by the Department.

To realize these savings, the Department may need to obtain or train Medicaid eligibility specialists and establish procedures to determine Medicaid eligibility for inmates and ensure that Medicaid eligibility is not terminated when inmates return from medical institutions. Federal reimbursement is available to offset some of the administrative costs that the Department may incur.

Although not within the scope of this audit, local governments could also realize savings by requiring medical providers to bill Medicaid for eligible inmate health care. Inquiry of officials in two counties and an organization that manages inmate health care for 45 counties indicates that local governments do not bill Medicaid for any inmate health care.

RECOMMENDATIONS

The Department should require hospitals and other medical providers to bill Medicaid for eligible inmate inpatient health care costs. The Department should work with the Department of Health and Human Services, County Directors of Social Services, and local governments to establish the necessary policies and procedures.

AGENCY'S RESPONSE

The Agency's response is included in the Appendix A.

FINDINGS AND RECOMMENDATIONS

\$11.5 MILLION A YEAR IN INMATE HEALTH CARE COST SAVINGS IS AVAILABLE

The Department of Correction (Department) could save about \$11.5 million a year by requiring hospitals and other medical service providers to bill Medicaid for eligible inmate inpatient hospital and professional services.¹ The amount of potential savings will increase when health care reform expands Medicaid eligibility in 2014. To realize these savings, the Department will need to determine Medicaid eligibility for inmates and ensure that Medicaid eligibility is not terminated when inmates return from medical institutions. Although not within the scope of this audit, it is also possible that local governments could reduce costs by charging eligible inmate health care to Medicaid.

Bill Eligible Inmate Inpatient Health Care Costs to Medicaid

Currently, the Department does not require hospitals or other medical service providers to bill Medicaid for any inmate health care costs. The Department pays for inmate health care at rates significantly higher than Medicaid rates. A previous state audit concluded that the Department pays an average of 467% (from 198% to as high as 879%) of Medicaid rates for inmate health care costs.²

The Department could reduce its inmate health care costs if medical providers billed Medicaid for inpatient services provided to Medicaid-eligible inmates. Inmates could be Medicaid eligible if they meet the Medicaid eligibility requirements, which include income and resource limits, citizenship and alien status, state of residence, 20 years old or younger, 65 years old or older, pregnant, blind, or disabled. Inmates could also be Medicaid eligible if they are considered physically or mentally disabled under the federal Supplemental Security Income (SSI) program. There are nine diagnostic categories of mental disorders under SSI including personality disorders and substance addiction disorders, which may establish disability.

Generally, the federal government will not reimburse states (called federal financial participation or FFP) for inmate medical care under the Medicaid program. However, an exception is allowed “during that part of the month in which the individual is not an inmate of a public institution.”³ For purposes of FFP, guidance from the Centers for Medicare and Medicaid Services⁴ (CMS) indicates that inmates lose their “inmate status” and obtain “inpatient status” when treated in an inpatient hospital setting that is not under the control of a state’s correction system. Consequently, FFP is available for an inmate’s health care expenses if the inmate is Medicaid eligible and he or she is an inpatient of a medical institution.

¹ Medicaid is a health insurance program funded by a state and federal partnership for low-income parents, children, seniors, and people with disabilities. The federal government provides a federal match to state government funding by reimbursing states a percentage of their Medicaid expenditures.

² Office of the State Auditor. Department of Correction Fiscal Control Audit. February 2010

³ 42 CFR 435.1008

⁴ CMS is part of the US Department of Health and Human Services. CMS is the federal agency that administers Medicare, Medicaid, and the Children’s Health Insurance Program. -

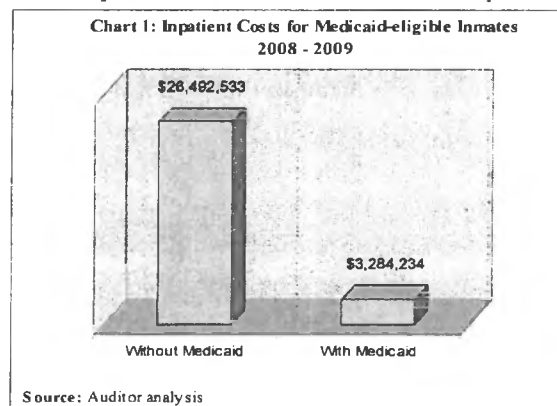
FINDINGS AND RECOMMENDATIONS

Correspondence from the CMS, formerly known as the Health Care Finance Administration (HCFA), a letter from the North Carolina Department of Health and Human Services (DHHS), and the experiences of five states confirm that FFP is available for inmate inpatient health care. Specifically:

- A May 4, 2010, CMS letter to the State Auditor says, “The North Carolina Medicaid program potentially could have been billed by enrolled Medicaid hospitals for services provided to inmates that are inpatients and are also Medicaid beneficiaries. Charges for professional services that occurred during the inpatient stays may also be billed on the Medicaid program.”⁵
- HCFA letters from 1997 and 1998 state, “An exception to the prohibition of FFP is permitted when an inmate becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an ‘inmate’ while an inpatient in these facilities provided the services are included under a State’s Medicaid plan and the ‘inmate’ is Medicaid eligible.”⁶
- An August 27, 2008, DHHS letter to County Directors of Social Services notes that “medical services received during an inpatient hospital stay for an incarcerated recipient” who is Medicaid eligible can be charged to Medicaid.⁷
- Five states (Louisiana, Mississippi, Nebraska, Oklahoma, and Washington) report that they charge eligible inmate inpatient health care to their Medicaid programs.

Billing Medicaid for eligible inmate health care costs would reduce the Department’s costs in two ways. First, the Department would realize reduced costs because hospital and medical services for eligible inmates would be reimbursed at Medicaid rates that are lower than the rates currently paid by the Department. Second, billing Medicaid for eligible inmate health care would reduce the Department’s costs by transferring those costs to the federal government because the federal government reimburses the State about \$.65 for every \$1.00 spent on Medicaid.

For example, Chart 1 shows that the Department paid about \$26.5 million in inpatient medical care for inmates who were potentially Medicaid eligible during the 2008 and 2009 calendar years. At Medicaid rates, those services would have only cost the Department about \$9.2 million, a \$17.3 million savings. Additionally, the federal government would have reimbursed the State about \$5.9 million. As a result, total cost to the



⁵ See appendix

⁶ See appendix

⁷ Division of Medical Assistance. DMA Administrative Letter No: 09-08, Medicaid Suspension. August 27, 2008

FINDINGS AND RECOMMENDATIONS

State would have been about \$3.3 million instead of \$26.5 million, a two-year savings of \$23 million or \$11.5 million a year.

Assuming that CMS does not change its current policy on inmate Medicaid eligibility, the Department could realize additional savings from the new health care reform law. Beginning January 1, 2014, the Patient Protection and Affordable Care Act “establishes a new eligibility category for all non-pregnant, non-Medicare eligible childless adults under age 65 who are not otherwise eligible for Medicaid and requires minimum Medicaid coverage at 133% FPL [federal poverty level].”⁸ Consequently, more inmates will become Medicaid eligible in 2014. Furthermore, states will receive 100% federal reimbursement for “newly eligible individuals” during the first three years: January 2014 through December 2016.⁹

Determine Inmate Medicaid Eligibility and Prevent Eligibility Termination

The Department does not currently have procedures in place to determine if an inmate who needs inpatient medical services is Medicaid eligible. Furthermore, the Department does not have personnel assigned to determine Medicaid eligibility.

To realize the potential cost-savings described above, the Department may need to obtain or train Medicaid eligibility specialists and will need to establish procedures to determine if inmates who are sent to medical institutions for inpatient services are Medicaid eligible. Medicaid eligibility for inmates can be determined at any time before, during, or after incarceration. In a 2004 letter to State Medicaid Directors,¹⁰ CMS said:

As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD [Institute for Mental Disease] does not affect the eligibility of an individual for the Medicaid program. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD.

Additionally, the State should be able to recover 50% of administrative costs the Department incurs for staffing, training, and performing Medicaid eligibility determinations. Federal regulations state FFP is available for salaries, fringe benefits, travel, training, and necessary administrative costs incurred in determining Medicaid eligibility.¹¹

Failure to timely determine Medicaid eligibility, however, can cost the Department money. For example, the Department cannot recover about \$23.2 million in potential savings for calendar years 2008 and 2009. During that period, the Department paid

⁸ The Henry J. Kaiser Family Foundation. Medicaid and Children’s Health Insurance Program Provisions in the New Health Reform Law. April 2010

⁹ Patient Protection and Affordable Care Act, Section 2001.(a)(3)

¹⁰ Letter from CMS to State Medicaid Directors dated May 25, 2004. Subject: Ending Chronic Homelessness.

¹¹ 42 CFR 432.50 and 42 CFR 435.1001

inpatient health care costs for 646 inmates who were potentially eligible for Medicaid. Federal regulations allow states two years to file and recover reimbursement for Medicaid claims if the individual was Medicaid eligible at the time of service.¹² But states can only look back three months before the eligibility application was filed to obtain retroactive reimbursement for Medicaid-eligible expenses.¹³ Consequently, the Department cannot recover the potential savings identified for calendar years 2008 and 2009.

After determining eligibility, the Department will also need to ensure that Medicaid eligibility is not terminated when inmates return from the hospital. CMS recommends, "Once determined eligible, the inmates remain eligible and their cases should be placed in a suspension status during their incarceration."¹⁴

It may also be advantageous for the Department to work with DHHS and local governments to ensure that Medicaid-eligible inmates do not have their eligibility status terminated when they are first incarcerated. In a September 2008 letter, DHHS directed County Directors of Social Services to suspend the Medicaid benefits of newly incarcerated individuals for the remainder of his or her "certification/payment review period."¹⁵ However, the Department may want to work with the County Directors of

TUESDAY, OCTOBER 18, 2011

Medicaid expansion seen covering nearly all state prisoners

By Christine Vestal, Stateline Staff Writer

The federal health law's controversial Medicaid expansion is expected to add billions to states' already overburdened Medicaid budgets. But it also offers a rarely discussed cost-cutting opportunity for state corrections agencies. Starting in 2014, virtually all state prison inmates could be eligible for Medicaid coverage of hospital stays—at the expense of the federal government.

In most states, Medicaid is not an option for prison inmates. But a little known federal rule allows coverage for Medicaid-eligible inmates who leave a prison and check into a private or community hospital. Technically, those who stay in the hospital for 24 hours or more are no longer considered prison inmates for the duration of their stay.

Here's how it works:

Under the 1965 law that created Medicaid, anyone entering a state prison lost Medicaid eligibility. The same went for people who entered local jails, juvenile lock-ups and state mental institutions. The reasoning was that states and local governments had historically taken responsibility for inmate health care so the federal-state Medicaid plan was not needed.

But an exception to that general rule opened up in 1997 when the U.S. Department of Health and Human Services wrote to state Medicaid directors saying inmates who leave state or local facilities for treatment in local hospitals can get their bills paid by Medicaid, if they are otherwise eligible. In addition to the incarcerated, those on probation or parole or under house arrest were among those who could participate.

Still, most state prisoners do not qualify for Medicaid. That's because all but a few states limit Medicaid to low-income juveniles, pregnant women, adults with disabilities and frail elders. The majority of people in lock-ups are able-bodied adults who do not qualify, even on the outside. In 2014, however, when Medicaid is slated to cover some 16 million more Americans, anyone with an income below 133 percent of the federal poverty line will become eligible. Since most people have little or no income once they are incarcerated, virtually all of the nation's 1.4 million state inmates would qualify for Medicaid.

As a bonus to state corrections agencies, most inmates would be considered new to Medicaid, making them eligible for 100 percent coverage by the federal government between 2014 and 2019. After that, states would be responsible for only 10 percent of their coverage. In addition, state health insurance exchanges—which are required to be functioning by 2014—would make it easier for corrections departments to sign inmates up for the program.

Few adopters

The 1997 ruling meant that even though a limited number of inmates would qualify, state corrections agencies could save millions in hospitalization costs because most hospital fees are lower for Medicaid patients and the federal government pays from 50 to 84 percent of the bill. The problem was, few corrections agencies heard

about the ruling. As a result, it took more than a decade for any state to take Washington up on its offer. “There has been a lot of confusion and misunderstanding about inmate Medicaid reimbursements” says Donna Strugar-Fritsch, a consultant with Health Management Associates who has been working with states to help them take advantage of the program.

Even among corrections officials who did find out about the opportunity, many were reluctant to talk to Medicaid officials about the complex law, she says. Another barrier has been that many hospitals oppose the idea because it means lower fees for patients they are already serving.

So far, only Louisiana, Mississippi, Nebraska, North Carolina, Oklahoma and Washington State have taken advantage of the ruling. California is preparing to launch a statewide reimbursement program this year. Alabama, Michigan, New Jersey and Utah are studying the idea.

Mississippi was among the first to make the change. Launched in 2009, its program has already saved the state \$10 million in inmate health care costs, says corrections commissioner Christopher Epps. The cost reduction comes partly from lower hospital fees and partly because 84 percent of the state’s Medicaid bills are paid by the federal government.

Dr. Gloria Perry, the chief medical officer for the Mississippi prison system, says her agency heard about the cost-cutting measure from a health care vendor looking for business in the state. The agency then verified the legality of the procedure with the state Medicaid office and quickly created a reimbursement program. No state laws or appropriations were required.

Using existing employees, Mississippi developed an internal system for signing up inmates and making sure hospital bills were paid by the Medicaid office. Corrections staff also met with hospital administrators to explain the change. “One or two hospitals were initially reluctant,” she says. But they are all cooperating now and submitting bills directly to the state Medicaid office for payment.

Out of 21,000 inmates in Mississippi, 242 have been approved for the program, and Medicaid reimbursements have paid for 2,088 days in the hospital. Perry says the most common reasons for hospitalization are childbirth, and treatment of cancer, liver and heart disease.

North Carolina launched a reimbursement program this year that includes all of the state’s 40,000 prison inmates. According to a 2010 auditor’s report, the state corrections agency is likely to shave about \$12 million from its \$160 million annual health care bill by requiring hospitals and skilled nursing facilities to seek payment directly from Medicaid.

California, with about 160,000 inmates, is likely to be the next state to launch a Medicaid inmate reimbursement program. Corrections officials say they expect to have an enrollment system up and running by the end of the year. The state also plans to use Medicaid to fund hospital stays for some 6,000 inmates of state mental institutions. In 2014, of course, virtually all of the state’s incarcerated will qualify for Medicaid-covered hospital stays.

—Contact Christine Vestal at cvestal@stateline.org

§ 435.1008 FFP in expenditures for medical assistance for individuals who have declared United States citizenship or nationality under section 1137(d) of the Act and with respect to whom the State has not documented citizenship and identity.

Except for individuals described in § 435.406(a)(1)(v), FFP will not be available to a State with respect to expenditures for medical assistance furnished to individuals unless the State has obtained satisfactory documentary evidence of citizenship or national status, as described in § 435.407 that complies with the requirements of section 1903(x) of the Act.
[72 FR 38694, July 13, 2007]

§ 435.1009 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to—

- (1) Individuals who are inmates of public institutions as defined in § 435.1010; or
- (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

[43 FR 45204, Sept. 29, 1978, as amended at 50 FR 13199, Apr. 3, 1985; 50 FR 38811, Sept. 25, 1985. Redesignated and amended at 71 FR 39225, July 12, 2006]

§ 435.1010 Definitions relating to institutional status.

For purposes of FFP, the following definitions apply:

Inmate of a public institution means a person who is living in a public institution.

An individual is not considered an inmate if—

(a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or

(b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who—

(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

Institution means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Medical institution means an institution that—

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

(c) Is authorized under State law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

The term "public institution" does not include—

(a) A medical institution as defined in this section;

(b) An intermediate care facility as defined in §§ 440.140 and 440.150 of this chapter;

(c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or

(d) A child-care institution as defined in this section with respect to—

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

JUNE 2004 A-04-02-06002

BACKGROUND

Section 1905 of Title XIX of the Social Security Act (the Act) states that Federal financial participation (FFP) is not available for services provided to inmates except when the inmate is not in a prison setting and becomes an inpatient in a medical institution.

FINDINGS

Outpatient Services: Improper Medicaid Payments

The four States made improper Medicaid payments for outpatient services provided to incarcerated beneficiaries. We reviewed 100 claims from each State and found that Medicaid paid:

- seven improper claims in Florida
- three improper claims in Massachusetts
- two improper claims in Missouri
- three improper claims in North Carolina

Inpatient Services: Cost Savings if Medicaid Payments Were Not Allowed

Medicaid payments for inpatient services for incarcerated beneficiaries who were not in a prison setting were allowable based on CMS policy. We found that Massachusetts and the Federal Government could have saved \$3,010,925 (\$1,505,462 FFP) if the Medicaid payment policy on inpatient health care services for incarcerated beneficiaries had been consistent with the policy on outpatient services. For the three other States, we did not identify a sufficient number of claims for incarcerated beneficiaries to allow us to make a reliable estimate of the potential savings.

Inpatient Services

From our universe of claims paid on behalf of incarcerated beneficiaries, we selected a stratified sample of 400 paid claims with each State representing a stratum of 100. The universe totaled \$130,862,277 and the sample totaled \$1,568,786. Table 2 shows the dollar value of the universe and sample for each State. For sample methodology, see Appendix B.

Table 2: INPATIENT SERVICES

State Universe Sample	
Florida	\$ 66,746,499 \$ 410,774
Massachusetts	18,169,765 534,071
Missouri	15,121,453 236,965
North Carolina	30,824,560
	386,976
Total	\$130,862,277 \$1,568,786

APPLICABLE LAW AND REGULATIONS

Section 1905 of the Act, implementing Federal regulations, and CMS guidance have made it clear that FFP under the Medicaid program is not available for any services provided to inmates, except when the inmate is not in a prison setting and becomes an inpatient in a medical institution.

On December 12, 1997, CMS issued a letter to all Associate Regional Administrators clarifying CMS's Medicaid coverage policy for inmates of a public institution. The guidance provides an exception to the prohibition of FFP for inmates, stating:

FFP is permitted when an individual becomes a patient in a medical institution. This occurs when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. Accordingly, FFP is available for any Medicaid covered services provided to an 'inmate' while an inpatient in these facilities. The letter also states that FFP is not available for inmates receiving care "on premises of prison jail, detention center, or other penal setting."

ATTORNEY GENERAL PAM BONDI

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Advisory Legal Opinion - AGO 2004-40

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Number: AGO 2004-40

Date: August 6, 2004

Subject: Indigent care surtax, Medicaid & inmate health payments

Mr. Joseph G. Jarret
Polk County Attorney
Drawer AT01, Post Office Box 9005
Bartow, Florida 33831-9005

RE: COUNTIES - INDIGENT CARE SURTAX - TAXATION - REFERENDUM - authority of county to use voter-approved indigent care surtax to pay county's mandatory Medicaid contributions; authority of county to use voter-approved indigent care surtax to pay costs of providing health care services and medical care to jail inmates. ss. 212.055(7) and 409.915, Fla. Stat.

Dear Mr. Jarret:

As county attorney for Polk County you have requested my opinion on substantially the following questions:

1. Can the voter-approved indigent care surtax provided for in section 212.055(7), Florida Statutes, and levied by Polk County in 2004 be used to pay Polk County's mandatory Medicaid contributions set out in section 409.915, Florida Statutes, which requires the county to pay the cost of certain hospital stays and portions of nursing home costs for Medicaid eligible patients?
2. Can the voter-approved indigent care surtax provided for in section 212.055(7), Florida Statutes, and levied by Polk County in 2004 be used to pay the costs incurred by the Polk County Sheriff's Office in providing health care services and needed medical care to jail inmates?

Question One

Section 212.055, Florida Statutes, authorizes counties and school boards to impose and collect discretionary sales surtaxes under legislatively prescribed conditions. As required by the Legislature "[e]ach enactment shall specify the types of counties authorized to levy; the rate or rates which may be imposed; the maximum length of time the surtax may be imposed, if any; the procedure which must be followed to secure voter approval, if required; the purpose for which the proceeds may be expended; and such other requirements as the Legislature may provide." [1]

Section 212.055(7), Florida Statutes, specifically provides for a voter-approved indigent care surtax. According to the statute:

"(a) The governing body in each county that has a population of less than 800,000 residents may levy an indigent care surtax pursuant to an ordinance conditioned to take effect only upon approval by a majority vote of the electors of the county voting in a referendum. The surtax may be levied at a rate not to exceed 0.5 percent, except that if a publicly supported medical school is located in the county, the rate shall not exceed 1 percent."

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Polk County adopted Ordinance 03-89, the Polk County Indigent Health Care Ordinance including the Polk County Health Care Plan, in December 2003. Subsequent to adoption of the ordinance, the voters of Polk County approved by referendum the levy and collection of an indigent care surtax of one-half cent.

Pursuant to section 212.055(7)(c), Florida Statutes, "[t]he ordinance adopted by the governing body providing for the imposition of the surtax must set forth a plan for providing health care services to *qualified residents*, as defined in paragraph (d)." (e.s.) The statute requires that the plan, and subsequent amendments to it,

"shall fund a broad range of health care services for indigent persons and the medically poor, including, but not limited to, primary care and preventive care, as well as hospital care. It shall emphasize a continuity of care in the most cost-effective setting, taking into consideration a high quality of care and geographic access. Where consistent with these objectives, it shall include, without limitation, services rendered by physicians, clinics, community hospitals, mental health centers, and alternative delivery sites, as well as at least one regional referral hospital where appropriate. It shall provide that agreements negotiated between the county and providers shall include reimbursement methodologies that take into account the cost of services rendered to eligible patients, recognize hospitals that render a disproportionate share of indigent care, provide other incentives to promote the delivery of charity care, and require cost containment, including, but not limited to, case management. The plan must also include innovative health care programs that provide cost-effective alternatives to traditional methods of service delivery and funding."

For purposes of this section, "qualified residents" are residents of the county who meet certain requirements.[2] "Qualified residents" must be certified by the authorizing county as medically poor. The statute contains specific language defining the medically poor for certification purposes:

"[P]ersons having insufficient income, resources, and assets to provide the needed medical care without using resources required to meet basic needs for shelter, food, clothing, and personal expenses; *not being eligible for any other state or federal program or having medical needs that are not covered by any such program*; or having insufficient third-party insurance coverage." [3] (e.s.)

You have asked whether the voter-approved indigent care surtax may be used to pay Polk County's mandatory Medicaid contributions pursuant to section 409.915, Florida Statutes.[4] Medicaid is a program that pays for medical assistance for qualifying individuals and families with low incomes and resources. The program became law in 1965 and is funded by both the states and the federal government and assists states in providing medical long-term care assistance to those who meet the eligibility criteria.[5]

Section 212.055(7)(d)2., Florida Statutes, states that a qualified resident who may be entitled to take advantage of the health care services provided with these funds may not be "eligible for any other state or federal program," i.e., the Medicaid program, or must have medical needs that are not otherwise covered by such programs. Thus, a Polk County resident who is eligible for Medicaid is not a "qualified resident" for purposes of expenditure of these funds unless the individual has medical needs not covered by the Medicaid program. Therefore, it is my opinion that the county could not bypass this statutory limitation by using these funds to pay the county's mandatory Medicaid contribution set forth in section 409.915, Florida Statutes.[6]

Question Two

You have also asked whether the voter-approved indigent care surtax may be used to pay for health care services and needed medical care for prisoners in county detention facilities.

The Florida Statutes make provision for financial responsibility for medical expenses incurred by county prisoners. These provisions are consistent with the proposition that providing services to those who are housed in the state's prisons should not come solely at the expense of taxpayers when the occupants themselves possess resources to cover such costs.[7]

Section 951.032(1), Florida Statutes, allows a county detention facility to recoup certain medical expenses from prisoners. Under this formula, reimbursement may be sought as follows:

"(a) From the prisoner or person receiving medical care, treatment, hospitalization, or transportation by deducting the cost from the prisoner's cash account on deposit

with the detention facility. If the prisoner's cash account does not contain sufficient funds to cover medical care, treatment, hospitalization, or transportation, then the detention facility may place a lien against the prisoner's cash account or other personal property, to provide payment in the event sufficient funds become available at a later time. Any existing lien may be carried over to future incarceration of the same prisoner as long as the future incarceration takes place within the county originating the lien and the future incarceration takes place within 3 years of the date the lien was placed against the prisoner's account or other personal property.

(b) From an insurance company, health care corporation, or other source if the prisoner or person is covered by an insurance policy or subscribes to a health care corporation or other source for those expenses."

Any prisoner who receives medical care, treatment, hospitalization, or transportation is required to cooperate with the county detention facility in seeking reimbursement for these expenses incurred on behalf of the prisoner. Section 951.032(2), Florida Statutes, authorizes the placement of a lien against a prisoner who willfully refuses to assist in reimbursement efforts by the detention facility. The prisoner's cash account or other personal property may be the subject of such a lien and the prisoner may also be denied gain-time.

However, to the extent that the resources described in 951.032, Florida Statutes, are not sufficient to fully reimburse a county detention facility for expenses incurred for providing medical care, treatment, hospitalization, or transportation to a county prisoner, the county itself is the liable party responsible for the medical care of a detained prisoner.[8] I am not aware of, and you have not brought to my attention, any prohibition against using voter-approved indigent care surtax moneys to pay for health care for indigent prisoners who satisfy the definition of a "qualified resident" pursuant to section 212.055(7)(d), Florida Statutes. Rather, the use of the permissive term "may" in section 951.032(1), Florida Statutes, appears to reflect a legislative recognition that the resources listed in the statute could require supplementation from other sources such as the indigent care surtax.[9]

Thus, it is my opinion that Polk County may use voter-approved indigent care surtax moneys to pay for health care services provided to jail inmates if the statutorily prescribed sources for reimbursement described above are insufficient and if the county prisoner is a "qualified resident" pursuant to section 212.055(7)(d), Florida Statutes.

Sincerely,

Charlie Crist
Attorney General

CC/tgh

[1] Section 212.055, Fla. Stat.

[2] See s. 212.055(7)(d), Fla. Stat., setting forth the requirements for "qualified residents" for purposes of subsection (7).

[3] Section 212.055(7)(d)2., Fla. Stat.

[4] Section 409.915, Fla. Stat., prescribes county contributions to Medicaid and authorizes the state to charge the counties for certain items of care and service.

[5] See "Welcome to Medicaid," at www.cms.hhs.gov/medicaid.

[6] See *Green v. Galvin*, 114 So. 2d 187 (1 DCA Fla. 1959), cert. den., 116 So. 2d 775 (Fla. 1959), appeal dismissed, 117 So. 2d 844 (Fla. 1960), for the proposition that a public official cannot do indirectly that which he is prohibited from doing directly.

[7] See *Williams v. Ergle*, 698 So. 2d 1294, 1295 (Fla. 5th DCA 1997), and citations therein.

[8] See *Department of Health and Rehabilitative Services v. Myers*, 696 So. 2d 863 (Fla. 4th DCA 1997).

[9] See *Fixel v. Clevenger*, 285 So. 2d 687 (Fla. 3rd DCA 1973); *City of Miami v.*

Save Brickell Avenue, Inc., 426 So. 2d 1100 (Fla. 3rd DCA Fla., 1983) (word "may" when given its ordinary meaning denotes permissive term rather than mandatory connotation of work "shall"); *compare*, s. 901.35, Fla. Stat., delineating responsibility for payment of expenses for the medical care, treatment, hospitalization, and transportation of persons injured during or at the time of arrest and providing that a health care provider "*shall seek reimbursement* for the expenses incurred in providing medical care" for certain prisoners injured at the time of arrest. (e.s.)

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Alaska



2012 State Legislative Priorities

Cancer has become one of the most preventable and increasingly curable life-threatening diseases – but only if we take the steps necessary to prevent it outright, detect it early, and improve access to care. To this end, the American Cancer Society Cancer Action Network (ACS CAN) in Alaska is working on the following legislative priorities in support of ACS CAN and the American Cancer Society's shared mission to end cancer as a major health problem.

Expanding Cancer Prevention, Treatment, and Survivorship

- **Colorectal Cancer Screening Coverage** – ACS CAN continues working to expand insurance coverage for colon cancer screening for non-state-regulated plans, bringing them to parity with Alaska state law, which requires screening coverage according to ACS guidelines.
- **Physical Activity and Nutrition** – ACS CAN supports funding for Alaska's Obesity Prevention and Control Program and its collaborative effort to prevent childhood obesity and chronic diseases, such as cancer.
- **Alaska Cancer Registry** – ACS CAN supports funding for the Alaska Cancer Registry's efforts to analyze incidence and survival data and monitor cancer trends for all cancer patients who reside in the state of Alaska.

Ensuring Access to Quality Care

- **Implementation of the Patient Protection and Affordable Care Act** – Inadequate access to timely, quality health care is one of the greatest barriers to winning the war on cancer. ACS CAN will support state legislation and regulations related to the federal Patient Protection and Affordable Care Act which seek to achieve adequate, available, affordable, and administratively simple health insurance coverage for all without regard to health status or risk. ACS CAN will oppose measures to limit or restrict this objective.
- **Clinical Trials** – ACS CAN supports measures to ensure benefits in self-insured plans cover the routine health care costs associated with clinical trials.

Lung Cancer and Tobacco Control

- **Smoke-Free** – ACS CAN will actively support comprehensive smoke-free measures, including campaigns and capacity building. ACS CAN will also continue education to increase knowledge level on this issue and oppose any weak or bad bills at either the state or local level.
- **Tobacco Prevention Program** – ACS CAN supports maintaining and growing Alaska's Tobacco Prevention and Control Program, especially to expand work around smokeless tobacco use in rural and Alaska Native communities. ACS CAN supports protecting Alaska's Tobacco Use Education and Cessation Fund, thereby preserving funding for tobacco prevention efforts. ACS CAN supports maintaining strong enforcement of youth access laws and guarding against attempts to weaken these laws.
- **Tobacco Taxes** – ACS CAN supports local and statewide measures to increase the price of cigarettes and other tobacco products. ACS CAN opposes measures to change the tax structure of smokeless products from "price-based" to "weight based," which would effectively reduce the price of certain tobacco products.
- **Youth Risk Behavior Survey** – ACS CAN supports measures which seek to improve the efficacy of the Youth Risk Behavior Survey.

For More Information, Contact: Emily Nenon, Alaska Government Relations Director, American Cancer Society Cancer Action Network, Great West Division • Office 907.277.8610 • Fax 907.273.2073 • www.acscan.org/alaska

ACS CAN, the nonprofit, nonpartisan advocacy partner of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit acscan.org.

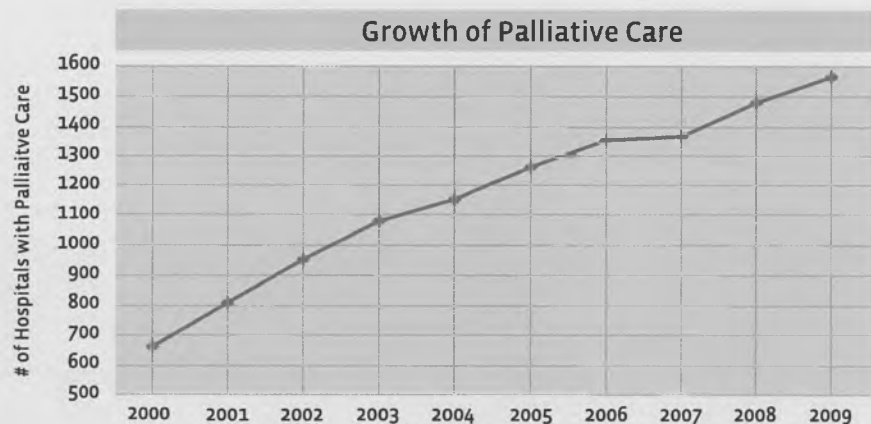
Palliative Care at a Glance

What is Palliative Care?

Palliative care, or palliative medicine, is specialized medical care for people facing serious and chronic illness. It focuses on relief from symptoms, pain, and stress – whatever the diagnosis. The goal is to improve quality of life for both patient and family. Palliative care is provided by a team that includes physicians, nurses, and other specialists who work together with a patient's own doctor to provide an extra layer of support. It is appropriate at any age and any stage in a serious illness and can be provided along with curative treatment.

Growing Trend in Health Care

Over the last ten years palliative care has been one of the fastest growing trends in health care. In fact, the number of palliative care programs within hospital settings has increased approximately 138%, from more than 600 in 2000 to more than 1500 today.



Source: Center to Advance Palliative Care, March 2011

This growth has occurred primarily in response to the increasing number of Americans living with serious and chronic illnesses and to the caregiving realities faced by their families. But palliative care has also been embraced for the simple reason it gives patients and families control and choice over their own care. The strong partnership of patient, family and the palliative care team assures that treatment goals are established and coordinated and full communication is maintained in what is often a long, complex course of serious illness.

People Want Palliative Care

Palliative care is expected to increase as the public becomes more aware of its benefits. Recent public opinion research by the national polling firm Public Opinion Strategies reveals that even for those patients who are uninformed about palliative care, once they understand what it is, **92% report they would be highly likely to consider palliative care** for themselves or their families if they had a serious illness. **92% also said they believe patients should have access** to this type of care at hospitals nationwide.

Quality Care Leads to Cost Reduction

Today, approximately 90 million Americans are living with serious illness, and this number is expected to more than double over the next 25 years. About 20% of all Medicare beneficiaries have 5 or more chronic conditions, and two-thirds of Medicare spending goes to cover their care. This patient population is also the most likely to benefit from palliative care. Recent studies indicate that by closely matching treatments with a patient's goals, and improving their quality of life, palliative care can provide substantial cost reduction.

Policy Changes Would Help

Policy initiatives that address workforce needs, research and patient access could rapidly bring palliative care to scale in the United States. The implementation of such policies would help meet the needs of our sickest children and a growing population of older Americans with long-term chronic conditions.



www.capc.org





ACS CAN: Making a Difference and Saving Lives

The American Cancer Society Cancer Action Network (ACS CAN) is the nation's leading voice advocating for public policies that are helping to defeat cancer. As the advocacy affiliate of the American Cancer Society, ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN utilizes its expert capacity in lobbying, policy, grassroots, and communications to amplify the voices of patients in support of laws and policies that save lives from cancer.

What's the Difference?

The American Cancer Society and ACS CAN are independent organizations that share the same goal: to save lives and to diminish suffering from cancer.

ACS and ACS CAN take different routes to meet these shared goals.

What ACS CAN Does

- Leads a national grassroots movement of cancer survivors and their families to support policies that help fight cancer
- Works with lawmakers from all political parties at all levels of government to make cancer a national priority
- Joins with diverse stakeholder groups in public campaigns supporting our advocacy priorities
- Educates the public, lawmakers, candidates, and the media about cancer issues

What the American Cancer Society Does

- Funds research
- Provides cancer information to the public
- Educates the public on cancer treatment, prevention, and early detection
- Works in local communities to help cancer patients
- Provides funding for advocacy and public policy work

You CAN Be Empowered

Defeating cancer is as much a matter of public policy as scientific discovery. Lawmakers play a critical role in determining how much progress we make as a country to defeating cancer. ACS CAN gives a voice to those impacted by cancer as they encourage lawmakers at all levels of government to join the fight to make cancer a national priority. By raising issues of importance, raising funds, educating voters and rallying others to the fight against cancer, ACS CAN unites and empowers you to make a difference and help save lives.

ACS CAN's work helps advance the Society's mission to defeat cancer by helping to protect and increase public investment in groundbreaking medical research, and by improving access nationwide to the latest prevention and early detection measures, treatments, and follow-up care that are proven to save lives.

Like cancer itself, ACS CAN is nonpartisan. ACS CAN does not endorse candidates or political parties, but it does educate voters by serving as a trusted source of information about candidate positions on cancer-related concerns and on key issue campaigns across the country that impact those affected by cancer.

ACS CAN in Action

ACS CAN helps to save lives from cancer through involvement, influence and impact.

Involvement – With a powerful grassroots movement of nearly a million strong and growing, ACS CAN ensures that the voices of patients, survivors and caregivers are heard in public policy debates in Congress and in state legislatures nationwide.

Influence – ACS CAN supports proven measures that help save lives and mobilizes cancer advocates in every state and every congressional district nationwide to hold lawmakers accountable to their constituents for the decisions they make related to cancer research, prevention, early detection and treatment.

Impact – ACS CAN's work has resulted in enormous progress through increased funding for cancer research and prevention programs; stronger tobacco control policies nationwide and improved access to the full range of cancer care for people diagnosed with the disease and their families



Obesity, Nutrition, Physical Activity and Cancer

Making healthy lifestyles a national priority

The Cancer Link

Obesity, physical inactivity, and poor nutrition are major risk factors for cancer, second only to tobacco use. One third of the more than 500,000 cancer deaths in the US this year can be attributed to poor diet, physical inactivity, and overweight and obesity. Currently, approximately two in three adults and one in three youth are overweight or obese.

Overweight and obesity are associated with increased risk for several common cancers, including colon, esophageal, kidney, endometrial and postmenopausal breast cancer. The biological link between overweight/obesity and cancer is believed to be related to multiple effects on fat and sugar metabolism, immune function, hormone levels and proteins that affect hormone levels, and other factors related to cell proliferation and growth. Maintaining a healthy body weight throughout life is key to reducing cancer risk.



Nutrition

Poor nutrition and the consumption of high-calorie foods and beverages are major contributors to overweight and obesity and increase risk of cancer. The American Cancer Society (ACS) recommends consuming a healthy diet, with an emphasis on plant foods, in order to reduce cancer risk. Recommendations include choosing foods and beverages in amounts that achieve and maintain a healthy weight, limiting consumption of processed and red meats, and consuming fruits and vegetables and whole grains instead of refined grain products. A recent study found that nonsmoking adults who followed the ACS guidelines for weight control, diet, physical activity, and alcohol had a lower risk of dying from cancer, cardiovascular diseases, and all causes.

Physical Activity

Regular physical activity helps maintain a healthy body weight by balancing caloric intake with energy expenditure. Physical activity may also reduce the risk of breast, colon, endometrium, and advanced prostate cancer, independent of body weight. ACS recommends that adults engage in at least 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity activity each week and that children and adolescents engage in at least 1 hour of moderate- or vigorous-intensity activity each day. Physical activity may often also be beneficial after a cancer diagnosis, reducing the risk of recurrence or death.

Combating the Problem

Despite the evidence linking overweight and obesity, poor nutrition, and physical inactivity to increased cancer risk, the majority of Americans are not meeting recommended nutrition and physical activity targets. Social, economic, environmental, and cultural factors strongly influence individual choices about diet and physical activity. Reversing obesity trends and reducing the associated cancer risk will require a broad range of strategies that include policy and environmental changes that make it easier for individuals to regularly make healthy diet and physical activity choices.

The American Cancer Society Cancer Action Network's (ACS CAN) advocacy work on obesity, nutrition, and physical activity is focused on creating social and physical environments and providing consumers with clear and consistent information that support making healthy lifestyle choices.

References Available Upon Request.

2012 American Cancer Society Cancer Action Network

Federal Advocacy Initiatives

Affordable Care Act

This law contains several key provisions focused on prevention and wellness. ACS CAN strongly supports the implementation of and opposes any efforts to dismantle these key provisions:

- **Calorie labeling of standard menu items in chain restaurants** and similar venues and of food and beverage items in certain vending machines.
- **Coverage of preventive health services, including obesity screening and counseling and behavioral interventions for weight loss, with no cost sharing** through private insurance plans in the new health insurance exchanges and Medicare, and an incentive for states to cover them in Medicaid.
- **The Prevention and Public Health Fund**, providing \$15 billion through 2019 and \$2 billion every year thereafter for prevention, wellness, and public health activities. A significant portion of this money has been spent on community-based initiatives focused on making community, school, and worksite environments healthier.
- **A National Prevention Strategy**, created by the National Prevention, Health Promotion, and Public Health Council, composed of senior officials from numerous government agencies, with input from an advisory committee of non-government experts – including the CEO of ACS CAN. The National Prevention Strategy provides a comprehensive plan for increasing the number of Americans who are healthy at all stages in life and includes healthy eating and active living as priority areas.



The Healthy, Hunger-Free Kids Act of 2010

This law includes a number of provisions focused on improving school nutrition and wellness, which ACS CAN strongly supports:

- **Updated national nutrition standards for school meals**, coupled with increased federal reimbursement;
- **National nutrition standards for foods sold in schools during the school day** outside of the school meal programs, including those in vending machines, school stores, and sold a la carte;
- **Strengthened local school wellness policies** that require school districts to set goals for physical activity, nutrition education and promotion, and foods sold outside of meal programs.

State & Local Advocacy Initiatives

There are also many ways that state and local governments can improve nutrition and increase physical activity through policy change.

- **Coordinated School Health** is an evidence-based approach to school health that involves changing the school environment to promote health through a coordinated strategy addressing key components such as physical education, health education, nutrition services, staff wellness, and family and community involvement.
- **Daily quality physical education** for students in grades K-12 provides them with structured physical activity and the information and skills to be physically active throughout their lifetimes. Physical education can be supplemented with additional school-based physical activity opportunities, such as recess, physical activity in the classroom, classroom breaks, intramural sports, and walk-to-school programs.
- **Complete Streets** aims to ensure that all users—pedestrians, bicyclists, motorists, and transit riders of all ages and abilities—have safe access to a community's streets. These and other initiatives, including Safe Routes to School programs, can increase opportunities for physical activity for transportation and recreation.
- **Access to healthy, affordable foods** can be increased through policies to incentivize supermarkets, convenience stores, farmers' markets, and community gardens.

References available upon request.



ALASKA

2011 State Cancer Facts

555 11th St N.W., Suite 300
Washington, D.C. 20004
(202) 661-5700
(202) 661-5750 (fax)
www.acscan.org

This year in Alaska:

- 3,090 people will be diagnosed with cancer, including
- 260 new colorectal cancer cases
- 460 new breast cancer cases, and
- 380 new lung cancer cases
- Cancer will kill 910 Alaska residents

This year in the United States:

- More than 1.5 million new cancer cases will be diagnosed
- Cancer will kill 571,950 Americans

Cancer Research and Prevention Funding in Alaska:

- Alaska received \$11.3 million in funding from the National Institutes of Health in Fiscal Year 2010
- Alaska received \$2.4 million in FY 2010 for the National Breast and Cervical Cancer Early Detection Program

Selected Research Accomplishments:

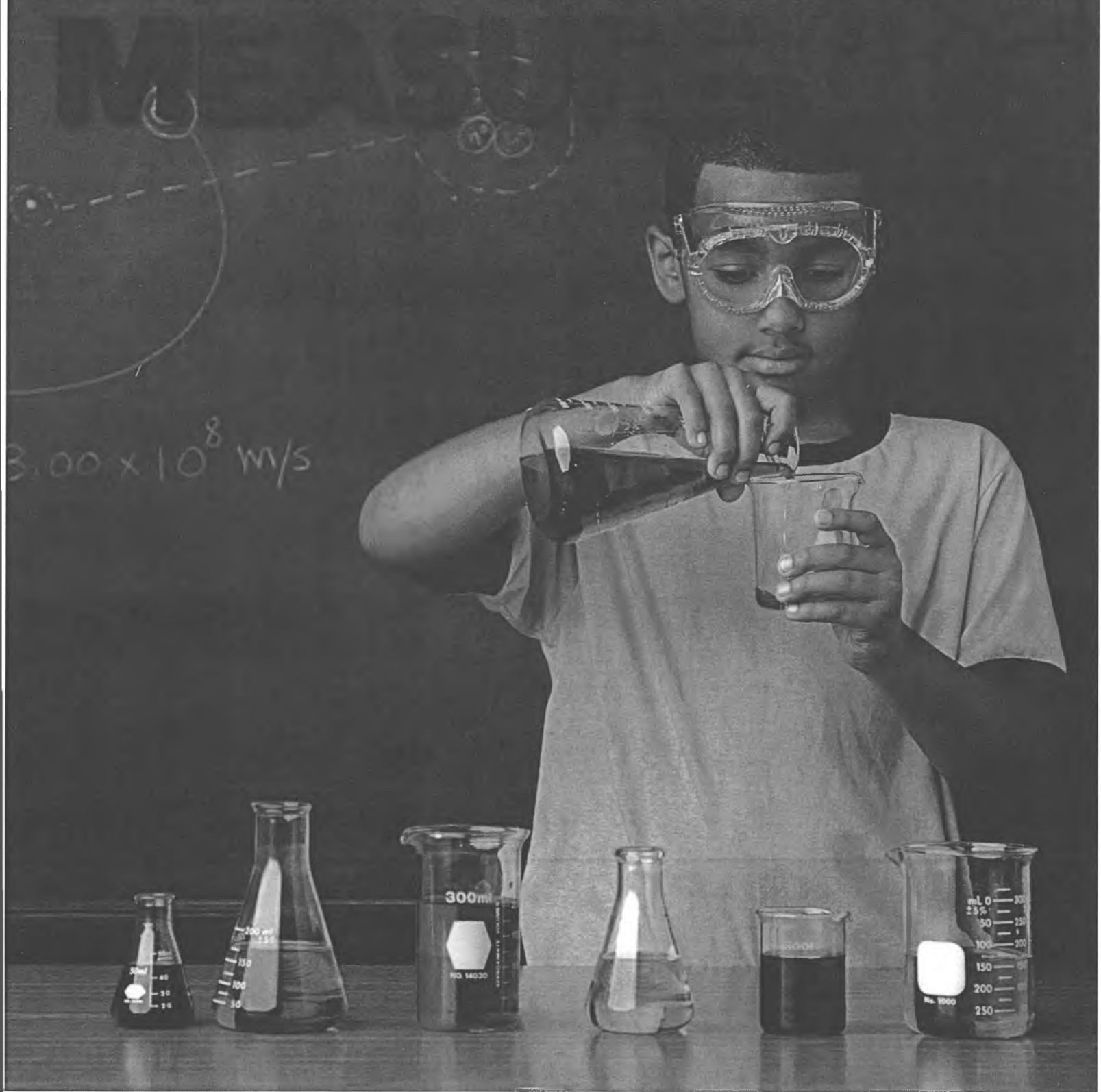
According to a study by The Cancer Genome Atlas (TCGA) Research Network, the most common form of malignant brain cancer in adults, glioblastoma multiforme (GBM), is not a single disease but appears to be four distinct molecular subtypes. Researchers also found that response to aggressive chemotherapy and radiation differed by subtype. Patients with one subtype treated with this strategy appeared to succumb to their disease at a rate approximately 50 percent slower than patients treated with less aggressive therapy. This effect was seen to a lesser degree or not at all the remaining subtypes. Researchers said the results may lead to more personalized approaches to treating groups of GBM patients based on their genomic alterations which may improve the near uniformly fatal prognosis of this cancer.

In a study supported by the National Cancer Institute scientists have found that cancer patients produce antibodies, as of part an immune system response that target abnormal glycoproteins, made by their tumors. The result of this work suggests that antitumor antibodies in the blood may provide a fruitful source of sensitive biomarkers for cancer detection. Scientists hope that such antibodies may ultimately have the potential to help doctors detect cancer by a simple blood test.

Scientists at the National Cancer Institute have established the presence of certain proteins in ovarian cancer tissues and have linked these proteins to poor survival rates in women with advanced stages of the disease. Abnormalities in a specific family of proteins have been found in several types of cancer, including ovarian cancer, but the mechanism and importance of such alterations in ovarian cancer was not defined. A researcher involved in the study, Christina M. Annunziata, M.D., Ph.D., has stated that "this study sheds light on the distinctive genetic features of the...pathway and may provide targets for the development of novel therapies for ovarian cancer."

**THE FOLLOWING DOCUMENT
HAS NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL FILE**

HOW DO YOU



A Progress Report on State Legislative Activity
to Reduce Cancer Incidence and Mortality

